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Official Report of Debates (Hansard)

G-35

Standing Committee on General Government

Strengthening Quality and Accountability for Patients Act, 2017

2nd Session
41st Parliament

Wednesday 15 November 2017

Chair: Grant Crack
Clerk: Sylwia Przezdziecki

Journal des débats (Hansard)

G-35

Comité permanent des affaires gouvernementales

Loi de 2017 renforçant la qualité et la responsabilité pour les patients

2e session
41e législature

Mercredi 15 novembre 2017

Président : Grant Crack
Greffière : Sylwia Przezdziecki

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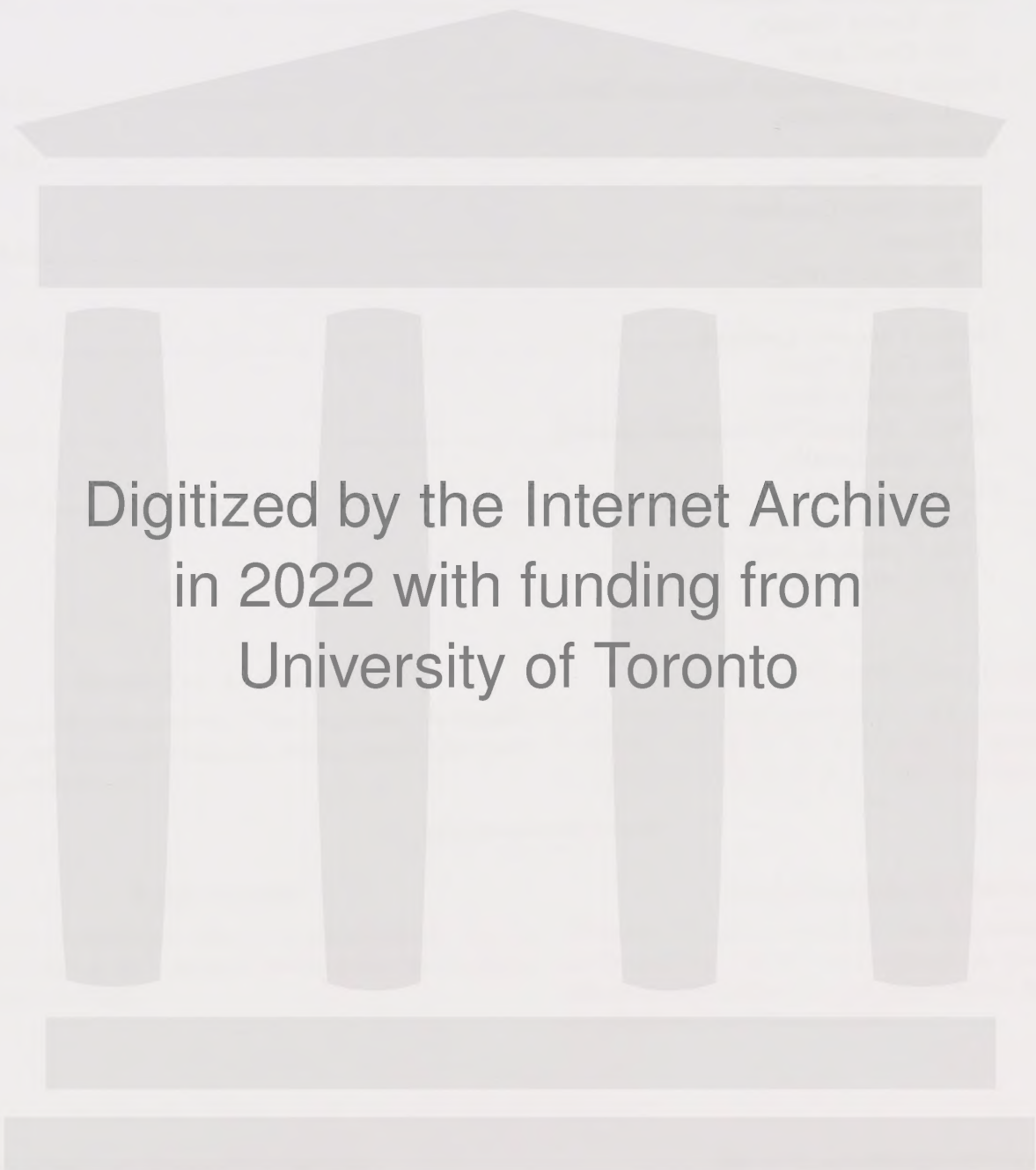

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON GENERAL GOVERNMENT

COMITÉ PERMANENT DES AFFAIRES GOUVERNEMENTALES

Wednesday 15 November 2017

Mercredi 15 novembre 2017

The committee met at 0831 in committee room 2.

STRENGTHENING QUALITY AND ACCOUNTABILITY FOR PATIENTS ACT, 2017

LOI DE 2017 RENFORÇANT LA QUALITÉ ET LA RESPONSABILITÉ POUR LES PATIENTS

Consideration of the following bill:

Bill 160, An Act to amend, repeal and enact various Acts in the interest of strengthening quality and accountability for patients / Projet de loi 160, Loi visant à modifier, à abroger et à édicter diverses lois dans le souci de renforcer la qualité et la responsabilité pour les patients.

The Chair (Mr. Grant Crack): Good morning, everyone. I'd like to call the Standing Committee on General Government to order. Today, we're going to proceed through public hearings with regard to Bill 160, An Act to amend, repeal and enact various Acts in the interest of strengthening quality and accountability for patients. We have a full agenda this morning.

ONTARIO MEDICAL ASSOCIATION

The Chair (Mr. Grant Crack): I'd like to welcome the first presenters this morning, the Ontario Medical Association. I believe we have the president, legal counsel and the director of health policy.

I welcome you to the front. I'll let you introduce yourselves for the record. You have up to five minutes for your presentation, followed by nine minutes of questioning from the three different parties, usually about three minutes each. Welcome. The floor is yours.

Dr. Shawn Whatley: Thank you, Mr. Chair. My name is Dr. Shawn Whatley. I'm the president of the Ontario Medical Association, and a family doc in Mount Albert, Ontario. With me today are Dara Laxer from health policy, and Jennifer Gold, our legal counsel.

The OMA represents Ontario's 30,000 practising physicians, and advocates on behalf of the medical profession and the people of Ontario in the pursuit of good health and excellence in health care. We appreciate the opportunity to present to this committee.

We support the intent of this legislation, specifically to improve quality and transparency across health care. That being said, we do have concerns that many of the proposals within the legislation lack important detail and are being left to future regulation, which makes it difficult for our members to provide constructive feedback.

We met with Ministry of Health officials to clarify some of the outstanding questions our members had about the intent of the legislation. However, I would strongly urge committee members to consider the outstanding questions before sending the bill back to the Legislature for third reading.

For my appearance today, I'll speak to the issues that impact physicians the most, specifically amendments to the Ambulance Act; health sector payment transparency; and community health facilities.

With respect to the Ambulance Act, Bill 160 amends the Ambulance Act, creating the framework for "treat and release." In other words, it authorizes paramedics to redirect patients to settings other than a hospital, or provide on-site care to avoid ambulance transportation altogether.

We acknowledge paramedics' critical role in providing advanced medical care, trauma and health support to patients. However, having reviewed the literature on this issue, the OMA raises concerns about the data used to support this change. There are no details provided to explain the target patient populations, parameters and/or situations under which paramedics would use their proposed expanded authority.

The OMA does not support an independent scope of practice for paramedics, as the current hospital system provides appropriate pre-hospital medical oversight of paramedics and ensures public safety.

As well, the lack of detail prevents us from providing informed comment without a clear understanding of the specific parameters of an expanded paramedic authority.

We welcome the opportunity to work with government to look at the data and identify system improvements.

With respect to the Health Sector Payment Transparency Act, we support proper transparency. Appropriate transparency allows policy-makers and the public to fully understand the consequences of health care spending and decision-making.

The OMA is concerned, however, that without the full context and explanation of the proposed disclosure, there may be negative impacts felt by patients and the system.

We worry that public disclosure of even nominal transfers of value from industry to physicians may result

in information without context being shared with the public that erodes the reputation of the health care providers and the health care system as a whole. Thus, we suggest that qualitative detail elaborating on the particular sources of funding be included in any public disclosure.

Furthermore, it is important to acknowledge the important role that industry currently plays in funding research, which includes fellowships, pharmaceutical products for patients, educational sessions and continuing medical education. The medical industry also provides discounts, training and support for expensive equipment and technology. Each of these areas represents important aspects of health care delivery that are not fully supported by public funds. Decreased transfers of value that result from the public disclosure should be offset by public funding; however, at the current time, the government is not proposing alternative sources of funding.

The bill also proposes that the corrections process for disclosed information will be defined in regulation. We urge government to work with those whose information will be disclosed to develop a reasonable corrections process to ensure that ample opportunity is provided to review their personal information.

Finally, the Oversight of Health Facilities and Devices Act: While on the surface the government's stated goal is one of implementing a single regulatory framework that modernizes oversight of community health facilities, again, we are concerned about the lack of detail. For example, the definitions of the bill are very broad. In fact, the definition of "facility" is so expansive that any place providing medical care could potentially be designated as a community health facility.

Similarly, the—

The Chair (Mr. Grant Crack): Thank you very much. Sorry, we have a full agenda and I have to stay within the five minutes. We'll start with the NDP: Ms. Gélinas.

M^me^ France Gélinas: I'll start with transparency, your second point. Has the OMA looked at all at the effects that similar legislation has had in the States? Have we seen anything good come of it—if you've looked at that at all?

Dr. Shawn Whatley: I'll answer briefly and then let our health policy staff answer. We believe transparency with qualitative information would be beneficial, but just a raw dollar value associated with a physician would not be helpful.

As to whether or not we've researched other jurisdictions, I'll let Dara—

Ms. Dara Laxer: We have looked into other jurisdictions. The key is stakeholder engagement in this and the importance of physicians, and others whose information will be disclosed, having the ability to participate and understand what specifically will be disclosed. In other jurisdictions, for example, they have been involved in the corrections process to understand what data will be on the list and to ensure that they have checked it and verified it. Similarly, the context that surrounds the disclosure is what is critical to ensure that information that is being provided to the public really is understood.

M^me^ France Gélinas: So could you name a jurisdiction—California has it, Vermont has some—

Ms. Dara Laxer: The US has this.

M^me^ France Gélinas: It's different from one state to the next? Is there one that is a model that you would like Ontario to follow?

Ms. Dara Laxer: Not necessarily. It's done at a national level across the United States.

M^me^ France Gélinas: Okay.

Ms. Dara Laxer: So the model, for example, with the corrections: Providers have 45 days to review the data that is provided. That could be an opportunity and an example of something we would like to see.

M^me^ France Gélinas: I did not have a chance to look at your entire brief. Are you putting forward specific requests that you would like to see in the bill?

Ms. Dara Laxer: Yes, we will be proposing amendments.

M^me^ France Gélinas: You will be proposing amendments? The sooner the better.

Ms. Dara Laxer: Sure.

M^me^ France Gélinas: With the oversight of health facilities act, could you give me an example of—because the definition of "facility" is so broad, you don't think that's the intention, but it could be and the problems with it?

Dr. Shawn Whatley: I think it's important that we sit down together and work out what this definition means. It's not something that we can just propose from the floor right here right now, but we need to get the definition correct or else this ends up being defined in regulation. We don't think that's a wise approach to developing legislation.

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M^me^ France Gélinas: You're a family physician. Is your fear that individual family physicians' practices may become a community health facility?

Dr. Shawn Whatley: Precisely.

M^me^ France Gélinas: Yes, I could see that. Will you be proposing definitions in your brief as to how we narrow the scope of the definition of a facility?

Dr. Shawn Whatley: I'll let Dara answer.

Ms. Dara Laxer: We will be proposing the development of a clarified framework for the executive officer and the importance of engaging prior to the development of regulation with stakeholders.

The Chair (Mr. Grant Crack): We'll move to the government side: Mr. Baker.

Mr. Yvan Baker: Thanks very much for coming in today and for your presentation. I have a couple of questions. Just broadly, you've spoken about a number of areas where you have suggestions for amendments or changes. Can you just talk a little bit about some of the elements of the bill that you think will be beneficial, how they could benefit the health care system?

Dr. Shawn Whatley: Absolutely. As I said in my remarks, we support transparency. I think it helps policy-

makers and providers as well as the patients to understand how dollars are being spent and how we can improve efficiency. In general, we support the intent of the legislation, but without details, it's very difficult for us to make specific comments on what we are worried about. If we can get the clarity, then we can offer more support. We'd love to help government to make this legislation a little stronger and more crisp.

Mr. Yvan Baker: I appreciate your input on this. Let's take a step back: Could you describe, right now, the relationship that exists between private industry and physicians in Ontario?

Dr. Shawn Whatley: Absolutely. Again, most of the relationship right now is around educational offerings. Private industry will host a conference. They might give a stipend to the speaker. The other place where we see private industry involved is with philanthropic gifts to hospitals. So, again, we support transparency around this, but simply attaching a dollar value to a doctor is really missing the whole qualitative piece, so I think it's important that people know what's going on. If you just stick a number there, I'm worried that doctors will stop doing this or we'll stop seeing funding for educational events. That will impact patient care.

Mr. Yvan Baker: So what I hear you saying, I think, if I can summarize, is that you support transparency and disclosure; you just want to make sure it's done properly?

Dr. Shawn Whatley: Absolutely.

Mr. Yvan Baker: Okay. Thank you.

The Chair (Mr. Grant Crack): We will move to the official opposition: Ms. MacLeod.

Ms. Lisa MacLeod: Thank you very much for coming in. I'm a bit of a write-in this morning, as our health critic actually is under the weather, so maybe we can send some OMA support to him this morning.

It's wonderful to be in here. I looked at your brief and I listened intently to the questions from my colleague in the third party with respect to the lack of detail and the concern you have that a lot of this will be part of a regulatory regime. You mentioned yourself that you want to make it stronger and, I'll use your words, "more crisp." Just to follow up on my colleague from the third party, do you have any specific amendments that you're prepared to make and do you want to share those with us at this point in time?

Dr. Shawn Whatley: Absolutely. I'll let Dara answer this.

Ms. Dara Laxer: So, specifically, if we're looking at the transparency piece, we are asking for an amendment to ensure that qualitative data is going to be captured as well. To Dr. Whatley's point, without the full context, it is not meaningful to the public, and the purpose of transparency is to inform the public.

In terms of the Ambulance Act, we do have specific amendments. We are concerned about the proposed expanded scope of practice and the diversion of patients. Because we have not been provided with any further detail or data as to the intent and the policy drivers on this, we have requested that this be struck and, as I've mentioned, in terms of the corrections process, we are asking for a period of approximately 60 days for providers to have a chance to review their data. Similarly, as mentioned, on the Oversight of Health Facilities and Devices Act, we are requesting that, in terms of the executive officer, we have an opportunity to be involved and review any sort of framework before it is developed in legislation.

Ms. Lisa MacLeod: Were you consulted prior to the tabling of this legislation?

Ms. Dara Laxer: We were consulted on the transparency piece. We were consulted over the summer on that. Some of our proposals were captured in the legislation, in the bill, but on the other aspects, we were not consulted.

Ms. Lisa MacLeod: Okay. And you're going to submit your amendments shortly, I suspect?

Ms. Dara Laxer: Yes, absolutely.

Ms. Lisa MacLeod: Okay. Thank you very much.

Ms. Dara Laxer: Thank you very much.

The Chair (Mr. Grant Crack): Thank you very much. We appreciate you coming before the committee this morning.

ONTARIO ASSOCIATION OF PARAMEDIC CHIEFS

The Chair (Mr. Grant Crack): We have next the Ontario Association of Paramedic Chiefs. We have the president, I believe, Mr. Neal Roberts, with us this morning.

We welcome you, sir. You have up to five minutes for your presentation, followed by nine minutes of questioning from the three parties. The floor is yours.

Mr. Neal Roberts: Thank you, sir. Good morning. My name is Neal Roberts. I am the president of the Ontario Association of Paramedic Chiefs. Thank you for inviting us to provide input on the amendments to the Ambulance Act contained in Bill 160.

I will start by introducing our organization and sharing our belief that most of the proposed amendments are long overdue, but I would be remiss if I didn't share our concerns with the amendments that we believe fail to put patients first. I will end with a proposal to take changes further and prioritize actions that evidence shows will achieve your goals faster.

First, the Ontario Association of Paramedic Chiefs represents the leadership of all 52 designated land-ambulance services in Ontario, Ornge and three First Nations services. Together, we oversee the lifesaving work of close to 9,000 primary, advanced and critical-care paramedics. Together, we are Ontario's leading authority for evidence-driven paramedicine and how it is delivered. Together, we applaud the province for many of the items proposed. Specifically, we welcome planned legislative amendments to the act that will expand the scope of certified paramedics to support on-scene assessment, treatment and referral or release. This will get Ontario closer to a comprehensive system where advanced clinical techniques and technologies are consistently

delivered in the community. This will improve health outcomes through seamless care from the first point of contact to arrival at a health care setting, whether that is a hospital or a clinic within a community.

Now to our concerns: While we support most of the proposed amendments, we stand united in our concerns about the proposal to allow paramedics on fire trucks. There is no—no—scientific evidence that patient outcomes will be improved by expanding medical responses by certified paramedics while they work on fire services, even when they arrive on scene before EMS. Sudden cardiac events are the only situations where clinical evidence shows that seconds truly matter. Firefighters and the public responding to a cardiac arrest already have the critical skills in CPR and public-access defibrillation to effectively respond to a sudden cardiac event. They already help save lives. There is no evidence that a primary-care paramedic arriving on a fire truck would improve a patient's outcome, and no patients, physicians or municipalities have advocated for this change.

We are not alone in our opposition. The Association of Municipalities of Ontario, the Large Urban Mayors' Caucus of Ontario, the Mayors and Regional Chairs of Ontario and the Emergency Services Steering Committee stand with us in their disagreement with this proposal.

There is also no medical evidence to support the proposed pilots for lower-acuity patients. These patients generally present with less or non-urgent symptoms. As I mentioned earlier, sudden cardiac events are the only situations where seconds truly matter. There is no evidence that faster responses to lower-acuity calls improve health outcomes. In fact, they may impact public safety because of the urgency of the response. Lower-acuity calls are best addressed within the standard EMS response framework. This puts patients first, as paramedics can perform detailed assessments that reveal underlying chronic illnesses that may be masking symptoms and affecting patient safety. It also keeps fire services focused on their critical and important primary role in the community.

Later this month, the ministry will begin consultations on the program designing clinical criteria for the firemedic pilot projects, but consideration of any new patient care models, liability frameworks and accountability of municipalities must happen at the same time and must be weighted on a province-wide basis. Patient safety is at risk without these considerations.

But there is a way to put patients first and reduce risk. Existing evidence shows that patient outcomes can and will be quickly improved with immediate improvements to the provincial land ambulance dispatch system. Diversion at the time of the 911 call, using timely and appropriate triage, can and will save more lives and have a more dramatic impact on health outcomes.

0850

This approach, coupled with technology upgrades to address increasing demand and call patterns, has been successful in other areas and can be replicated across Ontario.

For all Ontarians—

The Chair (Mr. Grant Crack): Thank you very much. We'll start with the government: Mr. Anderson.

Mr. Granville Anderson: Thank you, Mr. Roberts, for being here this morning. Do you want to finish off your thought?

Mr. Neal Roberts: I'd just simply say the rate prioritization will also decrease the demand to put more paramedics on the road unnecessarily, and local and provincial efforts will help reduce off-load delays. Thank you, sir.

Mr. Granville Anderson: Thank you for your overall support of this bill. I agree with you it's long overdue. I have a daughter who is a paramedic and she's also a registered nurse. We talk about that sometimes. She does see patients who really don't need to go to hospital. You know how our hospital waiting rooms are right now, so anything we can do to ease that pressure without putting patient safety at risk is valuable and it's a step in the right direction, as you well know.

Could you comment further on the benefits of having paramedics making the decision as to whether a patient is able to return or should be transferred to another medical facility?

Mr. Neal Roberts: Thank you for the question. Certainly we believe that paramedics provide an important role in health care, as we've already seen with community paramedics, which were introduced about three years ago. That's part of the integrated health care network, which allows patients who have chronic, complex underlying conditions and often are repeat callers of EMS land ambulance services to receive the care in their homes, coordinated with other health care providers.

That's really what this is about. If a patient doesn't need to go to an overcrowded emergency department that is receiving a lot of patients coming in, who could be treated with lower acuity issues, those are areas where we believe we could reduce or divert away.

In London, where I am the chief, there has been a mental health diversion, a pilot we put out there where we're trying to, again, divert a lot of the mental health patients who aren't high-acuity to the community. Those types of projects are where paramedics can assist in reducing the demand on the system.

Mr. Granville Anderson: Thank you. I don't know if my colleagues have any questions.

The Chair (Mr. Grant Crack): Thank you very much. We'll go to the official opposition. Ms. MacLeod.

Ms. Lisa MacLeod: Thank you very much, Mr. Roberts. You had a summary here. Would you like to complete that?

Mr. Neal Roberts: Just that, clearly, at the end of the day, we believe the focus of this act should be on technology and improvements to land ambulance dispatch. If you're going to put any emphasis on diversions or support to the system, it should be at the entry point. If you look at high-performance paramedic services around the world, this is where they're going, basically doing better triage.

We're still waiting for a triage system to be implemented in Ontario. The concern as well with the pilots is

that 70% of the time in London we're going out lights-and-sirens, and we're coming back 19% of the time lights-and-sirens. We're over-prioritized about 50%. The risk, even with the pilots, is that you're sending out even firefighter paramedics unnecessarily. You're not addressing the core issues that have been outstanding for years.

Ms. Lisa MacLeod: Can we talk a little more about this fire-medic proposal? Were you consulted on it prior to this bill being tabled?

Mr. Neal Roberts: We were, as part of the consultation. Certainly, the voice that we put forward throughout the process was not a support; it was to fix land ambulance dispatch, which our association and AMO and MARCO and LUMCO and, really, the municipalities that are responsible for land ambulance services have been saying for years.

We continue to not see the improvements we want, and yet the fire paramedics are being advanced ahead of this.

Ms. Lisa MacLeod: So this fire-medic proposal, then, came from the firefighters association?

Mr. Neal Roberts: That's our understanding, yes.

Ms. Lisa MacLeod: How would that work in terms of—help me with this. Would it be a firefighter who is trained as a paramedic or would it be somebody from your service that would actually be dispatched on the fire truck?

Mr. Neal Roberts: That's the clarity that we still don't have.

Ms. Lisa MacLeod: You're still looking for that.

Mr. Neal Roberts: It seems to be changing, because the program design and delivery have not been initiated or started. Certainly, all paramedics in the province, even if they are full-time firefighters, reside in an upper-tier municipality as a licensed paramedic. The responsibility, the liability, the training, the clinical oversight, rest with that upper-tier municipality. So we're attached to this file one way or another. Certainly that's part of the concern that we have as well: You just can't detach it, but you get to send back all the responsibility to the paramedic service.

Ms. Lisa MacLeod: So you're still very concerned about the lack of detail, similar to what the OMA suggested, in the bill.

Mr. Neal Roberts: Absolutely.

Ms. Lisa MacLeod: Will you be providing us with amendments as we move forward, anything specifically?

Mr. Neal Roberts: We'll be pleased to, especially with regard to the priorities that we think should be addressed in this act.

Ms. Lisa MacLeod: In terms of dispatch?

Mr. Neal Roberts: In terms of dispatch—even in the area with regard to the college of paramedics, which I know was touched on by the prior speaker as well.

Ms. Lisa MacLeod: Thank you so much.

The Chair (Mr. Grant Crack): Madame Gélinas?

M^me^ France Gélinas: Thank you for coming. My first question is about the diversion at the time of 911. You have referred to the fact that there has been success in other areas. Could you name me a jurisdiction in Canada that does this well?

Mr. Neal Roberts: I don't have specifics in Canada. Well, actually, Niagara right now uses this medical priority dispatch. That's the dispatch triage tool that we would like to have. I believe Toronto, as well, uses what's called an omega protocol. It's a further layer of triaging to determine whether or not a low-acuity patient requires a paramedic, requires a clinician on the floor to better triage the call coming in, whether they're required to go to their family physician or another health care provider. That is what you're seeing, actually—I was in the United Kingdom this summer, and they are spending a lot of time and resources on ensuring that when calls come in, they are getting the right resource.

M^me^ France Gélinas: Are you optimistic that something like this could be implemented province-wide in a timely manner?

Mr. Neal Roberts: We're still waiting for the medical priority dispatch system which was announced by the minister and the Premier in June of this year—for the contract to be signed, that has yet to be signed. We've been advocating since 2005 for this triage tool. So we're 11 years—

M^me^ France Gélinas: I'm fully aware, which is why I ask. It has been over a decade that you have been saying this, that we need a better triage, and it has not happened yet.

My second question is on off-load delays. In many parts of the province we're not going in the right direction, with less time for off-load delays, but longer. How do we cope with this when paramedics are no longer available because they're all sitting in a hospital?

Mr. Neal Roberts: It's a good point, Madame Gélinas. I guess part of the issue—we have had discussions with the government on this—is the over-triaging of calls, so unnecessarily sending a paramedic to get stuck in the emerg department. Part of it is system capacity, the lack of ability for alternative destinations or rerouting patients. Certainly, even in my own community, I'm seeing a 300% increase in off-load delays in certain months.

M^me^ France Gélinas: I'm worried about other destinations. I love the pilot that you have in London, that low-acuity mental health will go to a community mental health facility. But where else do you think you could safely take a person that has been deemed to need paramedic services?

Mr. Neal Roberts: Certainly what's been raised through our discussions are urgent care centres. We believe those are alternative areas.

M^me^ France Gélinas: Like the big walk-in clinics?

Mr. Neal Roberts: The big walk-in clinics, some of which are in hospitals, that are operating with an emergency department. Obviously, other clinics—but again, that's an area that we urge caution in proper care design on the program itself, to ensure that paramedics are supported with the appropriate training, with the appropriate resources and the appropriate support in this transition.

The Chair (Mr. Grant Crack): Thank you very much. I appreciate you coming before committee this morning and sharing your insight.

CUPE ONTARIO

The Chair (Mr. Grant Crack): Next we have on the agenda, from CUPE—we don't have the president, so I believe we have the chair? Is that correct?

Mr. Jason Fraser: Yes.

The Chair (Mr. Grant Crack): Okay. Mr. Fraser, if you would. You have up to five minutes. If you could introduce yourself and your colleague, it would be greatly appreciated. The floor is yours, sir.

Ms. Alison Davidson: I'm actually going to start, sorry, if that's okay.

The Chair (Mr. Grant Crack): Oh, okay, very good.

Ms. Alison Davidson: My name is Alison Davidson. I am a CUPE staff coordinator assigned to the municipal sector and the paramedic sector. With me is Jason Fraser, who is the chair of what's called CACO, the CUPE Ambulance Committee of Ontario. He is also, as he will tell you, a 15-year paramedic at two services here in the province.

We have provided you a brief which you can review, and we're free to answer questions you may have. I would just point out that CUPE in Ontario is the largest public sector union, representing over 260,000 members. We are the largest union in health care, representing over 78,000 members. I would point out that, as far as paramedics are concerned, we represent 5,000 of the 8,000 paramedics in the province of Ontario.

0900

Our presentation today will be focused on schedule 1, the Ambulance Act. Our brief contains all schedules, and there will be other representatives speaking to you at a later date.

In appendix D of our brief, you will see that CACO has voted in favour of the issue of diversion. We are in favour of diversion as contemplated in the act. However, we have some particular concerns around how that happens, and you will see that clearly.

However, we don't believe that the sole purpose of schedule 1 of Bill 160 is to introduce permissive legislation for diversion. We believe that the legislation is to allow for what are called fire-medics, or firefighters working as paramedics, in the province of Ontario, and we have grave concerns with that. In appendix A of our brief, you will see a detailed response on our concerns with regard to the firefighter issue.

Specifically with regard to Bill 160, section 22(1)(f) is at issue for us. We have provided proposed amendments, which you'll see in appendix C of our brief. However, I will note that, unfortunately, one page is missing, and we will clarify that for you.

It's 22(1)(f) that we'd like to speak about. We see that as extremely permissive. We see that that amendment, as proposed, could exempt the application of the Ambulance Act in a variety of negative ways—almost limitless, frankly. Notably, this could include the introduction of the fire-medic—the firefighter paramedic—proposal.

If diversion was the only goal for schedule 1 of Bill 160, you wouldn't need the language contemplated in 22(1)(f). We have to realize that diversion is not the only goal, but it is to allow for the firefighter proposal which, as Chief Roberts said, nobody is in favour of, except for the OPFFA.

On the issue of diversion specifically, hospitals, paramedic ambulance and ER systems are underfunded and lack capacity. The initiative of diversion will not solve that problem. Hospitals are the appropriate destination for most patients. Emergency medical services are not appropriate for detailed diagnosis, but hospitals are. Hospitals can provide a wide range of treatment.

On page 5 of our brief, there is a quotation from the Canadian Association of Emergency Physicians. Essentially, that quotation says that it's not about lower-acuity patients backlogging emergency departments but, rather, the lack of beds that are available in emergency departments.

We suggest that if the government is proposing directly to introduce a firefighter-paramedic model, then they should say so, and we should have a discussion on that point specifically.

CUPE would suggest that there be a deletion of 22(1)(f). However, in our proposed amendments, as you shall see, we believe that if you need 22(1)(f) to allow for diversion, there is a way to do that without opening it up so broadly that anything can come into play.

There are a lot of reasons why we are against the firefighter-paramedic model, specifically with regard to no oversight. I'll turn it over to Jason at this point to speak.

Mr. Jason Fraser: Thank you. In paramedic services, there is extreme, extensive oversight by legislation and regulation of land ambulance in the pre-hospital care setting. This is an extremely important service, vital to people's lives, as we are working in emergency situations. It cannot be done without extensive public oversight.

As you'll see in our brief, in appendix B, there are multiple pages that list the oversight that's required for land ambulance: patient care standards, reviews by peers done every three years, investigations, compliance by regulatory compliance programs, and the Ambulance Act. All these compliance standards are in place for the land ambulance services. To introduce paramedics on fire trucks—this oversight is not there. It is absolutely not there. It's essentially creating a shortcut to allow paramedics on fire trucks by excluding us in 22(1)(f)—

The Chair (Mr. Grant Crack): Thank you very much. I apologize; I have to stay within the five minutes.

We'll start with the official opposition: Ms. MacLeod.

Ms. Lisa MacLeod: Thank you both for coming. You didn't really get a chance to finish. Can I let you finish?

Mr. Jason Fraser: Sure, yes. That would be great. I just want to move on to diversion. As Alison stated, we do support diversion. We did put in an amendment on the

request of Minister Hoskins that we put some pen to paper. We have a list of public facilities that we would be willing to entertain, that we're comfortable with where we could actually take patients to. They're publicly funded. We didn't come up with those. I believe they came out of the LHIN act, are listed in that act, the public facilities where we would take patients.

We also believe diversion should only be done when paramedics have the proper training and the liabilities are in place to protect not only the paramedics but the patient as well. We need those guarantees for the paramedics and the dispatchers as well. If the dispatchers are going to be the ones who make the decisions on where they go, they need to be protected as well and have the proper training and oversight in place.

Ms. Lisa MacLeod: And you have, similar to the previous two deputations, some concerns around the lack of clarity and lack of detail in the legislation. There's a bit of ambiguity with respect to this certifier medic proposal. Could you speak a little bit more about what your concerns are? I think you had said something like it could be open to anything, what happens, and so what's your main concern there?

Mr. Jason Fraser: I guess it would be in relation to paramedics working on fire trucks. We already have land ambulance services in place; legislation is laid out. There's extensive oversight in land ambulance to protect the patient and the public. To duplicate that service and move it over to the fire service, they're not set up the same way. They don't have those protections in place. They don't have the legislation in place in the fire department service for pre-hospital care. We see that as a difficult pill to swallow, I guess, where it's not set up. It's a duplication of services. We believe that if we're going to invest more money into paramedics, then we should be investing into paramedic services, not the fire department.

Ms. Lisa MacLeod: Okay. You stated that obviously the group that we just had in here, the paramedic chiefs, yourselves and several different municipal organizations have all suggested there's concern with this proposal.

Mr. Jason Fraser: Yes.

Ms. Lisa MacLeod: Were you consulted previous to the tabling of the legislation?

Mr. Jason Fraser: Yes. We've been through the consultation processes over the summer. As I mentioned earlier, we did meet with Minister Hoskins at the beginning of October where he had asked us to put pen to paper and make amendments to schedule 1 of Bill 160 that we could—

Ms. Lisa MacLeod: And you've done that here in this—

Mr. Jason Fraser: We've done that. That's in there, and there is that one piece that's missing that we will provide in relation to 22(1)(f) where it sort of gives broad sweeping powers to make exemptions under the act.

Ms. Lisa MacLeod: Thank you.

The Chair (Mr. Grant Crack): Thank you very much. We'll move to the NDP. Madame Gélinas.

M^me^ France Gélinas: I don't know if you feel comfortable answering the question, but if you don't, don't.

The government has made it clear that they intend to go forward with the fire-medic pilot project in two communities. Do you know why, and what purpose does that serve?

Mr. Jason Fraser: I do not know why, unfortunately. I wish I had that answer. I think that's a question that a lot of people have: Why are they going forward with this when every group is against it except for one group, that being the OPFFA that's made the proposal? We heard from the OAPC before us, Chief Roberts. AMO is against it. I believe you'll probably be hearing from them over the next few days as well. The Large Urban Mayors' Caucus of Ontario, the biggest hospitals—there are several groups against it and one in favour. I think that is a significant question that needs to be answered. Why are we going forward with this when nobody wants it? It's going to increase costs to municipalities. It's going to increase liabilities and it's going to put people and patients at risk.

M^me^ France Gélinas: Switching topics, you said strongly that you support diversion. In the bill there is nothing that says this diversion won't be to a privately owned walk-in clinic, where you bring them there, you take your little number, you're number 42 and you realize that on the board it says "number 2."

Do you really support that kind of diversion?

Mr. Jason Fraser: We don't support that kind of diversion. We support going to public facilities.

0910

M^me^ France Gélinas: But it's not in the bill. In the bill, it just says "diversion."

Mr. Jason Fraser: Yes. In the bill it does. In our amendment, we have outlined that, that it's public facilities, and there are proper regulations, protocols and standards set out before this happens—

M^me^ France Gélinas: If we are not able to get those amendments forward, would you still support diversion in third reading?

Mr. Jason Fraser: I don't believe we would support that diversion at that point.

M^me^ France Gélinas: So for you to make sure that we continue to support the public, not-for-profit emergency support and everything else is a showstopper? If we don't get this, then your support for diversion dies with it?

Mr. Jason Fraser: Yes. I believe so, yes.

M^me^ France Gélinas: Okay. Thank you.

The Chair (Mr. Grant Crack): We'll move to the government: Mr. Anderson.

Mr. Granville Anderson: Thank you, Mr. Fraser and Ms. Davidson, for coming forward and for supporting the bill and certain principles in the bill.

I would agree that that's why we have these consultations. That's why we're having these hearings, because we want diversion. I am sure it will be designated where these patients will go in that case. It only makes sense that that would be there; we wouldn't want, arbitrarily,

just taking a patient anywhere—you agree with that? I am sure that will be a part of the bill as we go forward.

Could you expound a bit on the benefits of diversion and the benefits of your members using their skills to their full potential to enhance and to make patient care better in this province? Can you expound on that a bit?

Mr. Jason Fraser: I think with diversion and going to alternate facilities, it allows the paramedics to expand their skill level, use the tools that they have developed over the number of years they've been working and do what they're good at. Paramedics are extremely good at pre-hospital care and working in non-traditional places, whether it be a ditch or the back seat of a car.

It's good that, moving forward, we're giving a few more tools to help the patient, to get that patient some medical care a little bit quicker than going through a traditional ER. Again, I think that it's not the number of patients we're taking to the ER that's the issue; it's essentially the lack of funding in the hospitals and in paramedic services that matters, that is crowding the hospitals and causing paramedics to be on offload delay and not having the appropriate number of ambulances on the road. I think we need to look at the funding model for those services as well.

Mr. Granville Anderson: Yes, but it's not a funding issue when a patient ends up in emergency who is not supposed to be there. That has happened. I've heard people say to me, "The best way to get treated is to call an ambulance, because I'll jump the queue." A lot of that is happening, so we're trying to prevent that. That is going to improve patient care, wouldn't you agree?

Mr. Jason Fraser: Yes. I agree with that. That is the thought process by many, but I think we also have to think about, should we be judging what's a medical emergency to some person, right? We should be non-judgmental in this, I guess, because we don't think it's an emergency, but at that time, that person at that moment in their life felt the need to call an ambulance.

Mr. Granville Anderson: Yes, but that's where a paramedic is going to be able to make that decision to the best of their ability, and they will also have the broad sense that if the person is required to go to emergency, they will go there.

The Chair (Mr. Grant Crack): Thank you very much.

Mr. Jason Fraser: Thank you.

The Chair (Mr. Grant Crack): We appreciate both of you coming before committee this morning. Have a great day.

CG GROUP

The Chair (Mr. Grant Crack): Next we have the CG Group. I believe we have four members coming forward. I will let you introduce yourselves, in the name of time—

Interjection.

The Chair (Mr. Grant Crack): Okay. I believe Mr. Lowery is going to be the spokesperson. We welcome you all to committee this morning. You have up to five minutes for your presentation, followed by nine minutes of questioning. The floor is yours. Please introduce yourselves.

Mr. Jamie Lowery: First I want to thank the chairman and the committee for taking the time to hear from us.

My name is Jamie Lowery. I am the CEO of Cassellholme in North Bay. With me we have Chris Mayne, who is our chair and a city councillor; Mark King, who is vice-chair and a city councillor as well; and we have Don Gracey, who is our consultant on the project.

We are here representing all territorial district homes to this committee and recommend that schedule 5 of Bill 160 include another set of amendments. I believe we've forwarded all of those amendments to you for your review. Those amendments are absolutely necessary for us to redevelop. The redevelopment of the homes had been mandated by the Ministry of Health, and we want to certainly meet that deadline. Cassellholme—why we're here—is probably the most advanced with respect to our redevelopment plans. We've been working on it for quite some time. All of the other district homes are watching to see what happens and to see if these amendments are implemented.

I suspect many of you may be unfamiliar with the territorial district homes situation, so we provided a detailed description of what they are in our brief. But, in essence, it's really a northern Ontario organization or a northern phenomenon, as it were, in that they were established voluntarily back, quite frankly, almost a century ago. They operate as a not-for-profit. Many of us are registered charities, so we glean a lot of our funding from the community. But the interesting part is, the municipalities—we're not part of their legal or accounting entities. So the board of management—and two of our members are here—have the ability to establish a levy to support our operating capital costs.

The legislation applying to us, namely part VIII of the Long-Term Care Homes Act, is now, as I said, almost a century old. It really does harm us or hurt us when it comes to providing care for our residents.

The ministry's mandate for district homes to be redeveloped by 2025 has brought this particular urgency for the borrowing provisions in the act. Let me explain: The ministry does provide 60% to 70% of the funding of the capital costs. The rest of the payments are really up to the home, and we glean that sort of extra funding for the mortgage through the municipalities. Typically, it's done by a mortgage scenario, and it's held by the municipality. In the case of our home, it's North Bay.

The ministry suggested at one point that the way we could circumvent this borrowing issue was to convert to a not-for-profit. Cassellholme undertook a very substantive look at this. The end result was, when you apply the regulations to the scenario for creating the ability to borrow or to become a not-for-profit, it would lead to about 21,000 hours of clinical time being removed from our residents. That is quite substantial. The municipality,

the family council and the other municipalities were not willing to go down that road.

We're here asking the committee for amendments to allow district homes to raise their own mortgages on their own faith and credit. We have confirmed through Ernst and Young that we do have the ability to do that—we have the capacity to be a mortgagor—through competitive rates and terms, collateralized by our own assets and revenue streams. We have also confirmed that with our partners.

The other part of that is asking for us, the district home, to be able to accumulate reasonable operating reserves, similar to ones that are in southern Ontario. Why we think this is important is that, as the infrastructure ages, we want to have the ability to make sure we keep them current and also plan for unforeseen things like elevators, roofs and that kind of thing. This amendment that we put forward would allow us to do that.

The text of our amendments is attached in our submission at appendix A. We've done all of our due diligence, with the help of Don Gracey and a legal firm. What we are proposing also does not get northern municipalities out of the long-term-care business. Municipalities will still be part of a board of management. Municipalities would still contribute financially to the homes by way of an annual levy.

Just in closing, I don't want there to be any misunderstanding: In the two and a half years that we've been working on this—and I have to say that the ministry has been a very good partner for us. We've got support from our MPP. But if we don't get this ability, I'm afraid that our ability to redevelop just won't happen. Our seniors really deserve to have a decent place. We'll continue to operate as the home is in the current facility, but it really does complicate care. It's small, infection control is a problem and, I think, it really does add to the costs that take away from those residents who really need our help.

0920

I'm asking you to embrace the amendments we have put forward—consider them. We really need your help as an organization.

The Chair (Mr. Grant Crack): Thank you very much. We appreciate that. We will start with the government side. Ms. Wong.

Ms. Soo Wong: Thank you so much for being here today. As a former administrator of long-term care, I'm learning new terms. This phrase, "district homes"—I want to hear a little bit more. I see from your written submission there are five district homes in North Bay. Am I correct?

Mr. Jamie Lowery: No, it's in northern Ontario.

Ms. Soo Wong: In northern Ontario. Okay. So you have alluded in your closing remarks that you've been working with the Ministry of Health and Long-Term Care?

Mr. Jamie Lowery: Correct.

Ms. Soo Wong: Are you C or D facilities?

Mr. Jamie Lowery: We are B and C.

Ms. Soo Wong: B and C. Okay. I want to hear a little bit more in terms of patient care and patient safety. Are you working with the ministry to address the issue of community-based care? Because we will never build enough long-term care—let's call it the way it is. I want to hear, from your organization, Cassellholme, what you are doing besides the long-term-care beds.

Mr. Jamie Lowery: Well, it's interesting that for a model put forward, it actually puts long-term care more as a subset of what we're trying to do. When we redevelop, we're actually creating—there's a piece of the building that's left over, which was just recently constructed in 1993. We've been working with the hospital. We've been working with the DSSAB, which are social services. We've been working with the Alzheimer society. We want to create a place where it becomes more of an outreach, so we're not bringing people in or counting on the long-term care; we're actually looking to care for the community.

We have five buildings. This is some of the irony, that we have been able to borrow on our own faith and credit to establish seniors' buildings on our site. We already have those things. We've done full consultation to make sure that it's not just addressing long-term care, because you're right that there will never be enough. But, certainly, putting forward a model that is a system adjustment—it really does address people who are at risk and potentially at risk, giving them choices of where they want to be cared for.

Ms. Soo Wong: And I notice in your written submission and also in your presentation this morning, there is no mention of the LHINs. What's your relationship with the LHIN about your submission to—

Mr. Jamie Lowery: Our submission has been supported in writing by the LHIN.

Ms. Soo Wong: Okay. That's good to know. The other piece I also want to hear—your model is uniquely northern Ontario, because you've written that in your submission. Besides these legislative changes, you're asking us to be more flexible, to address the support. What else could we be doing in terms of patient safety in Bill 160? I want to hear that conversation about patient safety.

Mr. Jamie Lowery: For the most part, I think the bill does add to patient safety; I really do think that. I think that there are some concerns about directives to organizations. I think most organizations in the not-for-profit municipal are indeed focused on patient care first; that is my belief. I think that there are some issues related to compliance in some homes, and that being able to engage and to work with compliance, in order to help homes become more compliant, to help them, would be beneficial.

The Chair (Mr. Grant Crack): Thank you very much. We appreciate that. We'll move to Mr. Fedeli from the official opposition.

Mr. Victor Fedeli: Thank you very much, Chair. I want to welcome everybody here, old friends and familiar faces from North Bay. Thank you for your great

work on this project. You described something new to many people here in the south: territorial district homes. That is a new expression down here, not so new where we live. Give us an idea of the scope of this. What kind of money are we talking about for this whole development?

Mr. Jamie Lowery: I think just for the long-term component of it, $60 million is what we're looking at. But that's really only a portion of the development. I think there's a real appetite to see this be much more of a community spot for seniors.

In working with the hospital, for example, we're looking at a community health clinic, and really—it was interesting to be here to hear the earlier discussion—we're looking for a safe place for seniors to go to receive care. We calculated that in a three-month period we do 234 transfers to the hospital. That's a lot of transfers and it's a lot of time in those rooms. Often, what happens is that they have to be cared for by a caregiver, so they are sitting there.

So we're trying to really adjust the system with this model and working with all of our partners to make sure that it's more than just long-term care; it's looking at a broader scope.

Mr. Victor Fedeli: The bottom line is that you can't raise your own money from a mortgage. You cannot take out a mortgage. That's the way the rules are today.

Mr. Jamie Lowery: On the Cassellholme site; correct.

Mr. Victor Fedeli: So you must rely on one of your member municipalities—the city of North Bay and/or the other partners. They're either not prepared to or not able to accommodate that financially. Is that the bottom line today?

Mr. Jamie Lowery: In speaking with the municipality—again, I have two council members here—the current debt level at the city of North Bay is $60 million. This would, in fact, double their debt.

Mr. Victor Fedeli: So you're asking that amendments be brought forward that will allow you to be your own mortgagor.

Mr. Jamie Lowery: Correct.

Mr. Victor Fedeli: Why do you think that this Legislature will be able to do that? Have you talked to any ministries that seem to feel this is an appropriate approach?

Mr. Jamie Lowery: As I said earlier, we have spoken to the Ministry of Health. They are very supportive. Through Don, we have had conversations with the Ministry of Municipal Affairs. I think the overall sense is, they want to get on with development.

Mr. Victor Fedeli: You talk about being able to accumulate the reserves as well, like long-term-care homes in the south. Why do you think there's a difference between how the homes in the south are treated and the homes in the north are treated?

Mr. Jamie Lowery: It's different legislation. We're very different. As I said, there's no binding legislation to keep North Bay in the long-term-care business. They could give their five years' notice and they're out.

Mr. Victor Fedeli: Thank you very much. It was great to see you guys come to Toronto from North Bay.

The Chair (Mr. Grant Crack): We'll go to the third party. Madame Gélinas.

M^me^ France Gélinas: Thank you for coming and for explaining. Because you have been at it for so long, I'm surprised we haven't done that yet. Going from 15% to 25%—who said no to that?

Mr. Jamie Lowery: The act, as I understand it—maybe Don can help me out—has never really been addressed and opened up. The act has not been opened up to some changes. It has evolved with certain legislation, but really, that component of it has never been discussed.

M^me^ France Gélinas: So now you see an opportunity to put that in, because the Long-Term Care Homes Act is being opened.

I have no problem putting those amendments forward. I can guarantee you that I will put those amendments forward.

The Liberals have a majority. Could you give me arguments as to why they would say no to that? Every home in the south is allowed to borrow against their own assets. Why is it that because we live in northern Ontario we have to be dealt with differently? Your assets are just as valuable as an asset in the south. Why can you not borrow against it?

Mr. Don Gracey: I think I can answer that. The issue here is primarily with municipal affairs and the precedent that this would set for municipalities borrowing. Municipal affairs is concerned that this is, or may be perceived as, off-book financing. As a federal public servant, I've got a lot of experience with public finance. This is not off-book financing—it simply isn't—and therefore would establish no precedent. But that is the issue that municipal affairs is trying to grapple with.

As Jamie said, unless this is resolved, the redevelopment that we've talked about will not happen.

M^me^ France Gélinas: I fully understand that.

You have a beautiful home, you provide very high-quality care, and I certainly encourage you to push forward. I will try to help you as much as I can. I understand that you stand on your own. You have a history of being wise with your money and providing good care to your residents, and you want to redevelop in something that will be so good for the senior population of North Bay and area. It has to happen.

0930

If those two changes that are a given for anybody in the south are not allowed for northern Ontario, we have something drastically wrong happening here. We will support you as much as we can and let you know how it goes.

The Chair (Mr. Grant Crack): Thank you very much. I'd like to thank you gentlemen for coming before committee this morning. We appreciate your input.

ONTARIO CAREGIVER COALITION

The Chair (Mr. Grant Crack): Next on the agenda, we have the Ontario Caregiver Coalition. We have two

individuals coming forward: Ms. Shamji, who is the manager of government relations, and Cheryl Perera, who is the chair, I believe. We welcome you. If I have mispronounced your names, feel free to put them into the record.

Welcome. You have up to five minutes.

Ms. Cheryl Perera: Thank you very much for having us.

We are from the Ontario Caregiver Coalition—hello, MPP France Gélinas—and we are very pleased to be here to support an amendment to Bill 160 to include a declaration of Family Caregiver Day.

The Ontario Caregiver Coalition was established in 2009 and has grown from just under 30 members to over 180 members currently. We are a diverse and broad cross-section of one in five Ontarians who are caregivers. We represent a number of different organizations and individual caregivers.

Our mission states that the Ontario Caregiver Coalition is dedicated to recognizing the importance of unpaid caregivers in Ontario by raising awareness of the value that they add to the health care system and by advocating for improved fair access to needed supports. We strive to be the voice of caregivers in the province.

Ms. Abidah Shamji: Across the province, over three million people provide supports for family members facing illness, disability or challenges related to aging, but their contributions often go unrecognized.

The coalition celebrates Family Caregiver Day each year on the first Tuesday of April to unmask the invisible heroes of the health care system, and their faces may surprise you. Last year we highlighted three generations of caregivers, each with their own challenges. We saw young carers; over 500,000 family caregivers in Ontario are between 15 and 24 years of age. We saw the sandwich generation; those are caregivers who provide care for both their aging parents as well as their own children. Then, elderly caregivers; nearly 375,000 caregivers in Ontario are over 65 years of age.

Family Caregiver Day aims to raise awareness about the importance of family caregivers in Ontario and how much they do for us.

With respect to Bill 160, An Act to amend, repeal and enact various Acts in the interest of strengthening quality and accountability for patients, we're asking that schedule 5 to the bill be amended by adding the following section entitled "Family Caregiver Day," where the first Tuesday of April in each year is proclaimed as an official Family Caregiver Day.

The purpose of this section is to recognize family caregivers, which is the term used for a family member, friend or person of choice who gives unpaid care to someone who has care needs due to a disability, a physical, neurological or mental condition, a chronic illness, frailty, or age, in the belief that recognition and awareness of these caregivers should be increased and their valuable social and economic contribution to society should be acknowledged and supported.

At some point in our lives, everyone will either be a caregiver or be a care recipient, and it is important that we do not underestimate or forget how integral family caregivers are to our province.

We thank the committee for consideration of this amendment in recognition of the significant work that caregivers provide day in and day out.

The Chair (Mr. Grant Crack): Thank you very much. I appreciate that.

We'll start with the official opposition. Mr. Smith.

Mr. Todd Smith: Thank you, ladies, for coming in today and speaking to us.

Have you ever put a dollar value on how much it would cost if we had to pay all of the family caregivers in Ontario? How much are your members actually saving the system?

Ms. Cheryl Perera: It's millions and millions of dollars. If you think about it, there are three million caregivers in Ontario that we know of. The cost of a personal support worker is around $20 an hour. Each caregiver is doing, on average, somewhere between 10—some of them are doing it full-time, so you can just do the math right there. It's an incredible amount of money.

Our health system would be crippled without these family caregivers, and it would mean a lot to them to be recognized by the province in this way.

Mr. Todd Smith: Absolutely. Do you have any other concerns or thoughts on Bill 160 that you'd like to share with the committee?

Ms. Abidah Shamji: We came here today just for the particular declaration. It would mean a lot to us to have family caregivers recognized in this official capacity.

Mr. Todd Smith: Sure. Okay.

Ms. Cheryl Perera: It certainly aligns with the Ministry of Health plans really talking about recognizing caregivers and client-voice-type strategies. I think it's really consistent with everything else that's being done in the province right now.

Mr. Todd Smith: Okay. You have the support of our caucus on schedule 5 and the amendments. Thank you for coming today.

Ms. Cheryl Perera: Thank you.

The Chair (Mr. Grant Crack): Madame Gélinas.

M^me^ France Gélinas: Thank you so much for coming, and a pleasure to see you always. I know it's not easy to come to Queen's Park, so I appreciate the effort you made to be here this morning.

I, like the colleagues before me, truly support all of the incredible work that your membership does and the need to be recognized. I would say that still for a lot of Ontarians, the thought that caregivers need to be—they do amazing work but in the shadows. We don't see them, we don't hear about them, and you have started to recognize them. You've given us some examples, and this is wonderful. I can say that in my riding, we recognize caregivers also and it brings out the best in people. It teaches us empathy. It makes us a better society.

I can tell you that I fully support this and will help very much to push it forward in talking to different

people. Has anybody ever said, "No, this is not a good idea" or "This is not a good day" or none of the above?

Ms. Cheryl Perera: No.

M^me^ France Gélinas: No? So everybody is in support? Do you know why the first Tuesday of April was chosen?

Ms. Cheryl Perera: It is also national caregiver day and so it makes sense to match the national caregiver day. We know other provinces have declared a caregiver day in the province. Manitoba would be an example of that. It really further emphasizes for caregivers in the province that they're valued.

M^me^ France Gélinas: I fully agree. We will try really hard to make this amendment to schedule 5, and hopefully everybody will see it that way. Thank you for coming.

Ms. Cheryl Perera: Thank you, MPP Gélinas.

The Chair (Mr. Grant Crack): We'll move to the government. Mr. Baker.

Mr. Yvan Baker: Thank you very much for coming in and for your presentation, and thank you for your advocacy on behalf of caregivers.

It's interesting; I was elected about three and a half years ago and represent a community called Etobicoke Centre. It's a suburban community here in the city of Toronto, and we have one of the highest percentages of seniors of any riding in the country. One of the issues that very quickly came forward—or the issue that a lot of people are concerned about, whether it be from seniors or from families—is health care. One of the things that became very apparent early on in the term—I hosted a consultation in the community on the issue of dementia and Alzheimer's, and one of the things that stood out for me and, I think, for many others was the impact that dementia and Alzheimer's has on caregivers, who are doing their best to support those who are struggling with dementia and Alzheimer's. That's just one example of the important role that caregivers play, but we need to make sure that that's something that we are aware of and we're doing all we can to support caregivers.

One of the pieces of the legislation is schedule 4, which is the health sector payment and transparency component. Can you speak to your perspective on schedule 4 and how you think it will help patients be more informed about health care services?

Ms. Cheryl Perera: I'm sorry, I'm not actually familiar with that piece. Certainly we would support transparency, though, but unfortunately I can't comment specifically on that.

Mr. Yvan Baker: Yes. That's just so you're aware. That's the component of the legislation that would require that certain information about financial transfers from the private sector, in particular to health care providers, be made transparent, be made available. That's basically what that does.

Okay. Thank you, Chair.

The Chair (Mr. Grant Crack): Thank you very much for the two of you coming before committee this morning. It's much appreciated. Have a great day.

0940

OPSEU, HOSPITAL PROFESSIONALS DIVISION

The Chair (Mr. Grant Crack): Next on the agenda, we have, from OPSEU, the hospital professionals division. We have Sara Labelle, who is the OPSEU chair. We welcome you. I believe you have another individual with you. If you could, just introduce yourself and her as well. We welcome your presentation. You have up to five minutes.

Ms. Sara Labelle: Five minutes? Really?

The Chair (Mr. Grant Crack): Click.

Ms. Sara Labelle: Okay, I thought it was 10.

The Chair (Mr. Grant Crack): Oh.

Ms. Sara Labelle: Just a second, let me do my timer. You're making me talk in half the time, so I'll talk twice as fast.

My name is Sara Labelle and I have Kim Johnston from our campaigns department with me. I am the chair of the hospital professionals division. Thank you for the opportunity to present today on Bill 160. I'm the chair of the hospital professionals division. We represent about 25,000 hospital professionals in 90 hospitals across the province.

While we are deeply concerned about many of the changes proposed in Bill 160, today I will be focusing specifically on those proposed under schedule 9. Before I really get into it, I want to just express my concern that most of the provisions in Bill 160 have undergone no public consultation. It is being fast-tracked with only four days of public hearings solely in Toronto. This poor process has resulted in poor legislation.

Without any public consultation, schedule 9 is set to repeal the Private Hospitals Act, the Independent Health Facilities Act and the Healing Arts Radiation Protection Act. It enacts new legislation called the Oversight of Health Facilities and Devices Act.

The new act lifts the ban on private hospitals, falsely renames private clinics as "community health facilities" and contains broad ability for these private clinics to appeal decisions of the Ministry of Health and Long-Term Care. It does not require new clinics to be non-profit. It does nothing to improve quality of care or protect patients against user fees and extra charges, and almost all significant aspects of the legislation are left to future regulation. It allows the ministry to bring in a proliferation of fully private, for-profit hospitals and clinics with the stroke of a pen.

For these reasons, we are calling for schedule 9 to be repealed immediately.

Why is the Oversight of Health Facilities and Devices Act so problematic?

The rebranding of private hospitals and IHFs as "community health facilities" under the new legislation is not only misleading, but an affront to the notion of the non-profit community health sector: 98% of these IHFs are for-profit corporations and they differ significantly

from the existing community health sector. The Oversight of Health Facilities and Devices Act allows these newly branded "community health facilities" to provide services prescribed in regulations. As such, the minister can now widen the scope of private clinics with few, if any, limits. This is dangerous, and we oppose it in the strongest terms.

The new act sets up an executive officer whose powers are yet to be determined via future regulations in the act. The new act undermines the minister's previous powers and gives the EO the power to request applications at any time for the establishment of a so-called "community health facility." By doing so, the act gives authority to an unelected individual with immense powers to privatize. The legislation will also allow any person to apply for a licence to operate a CHF at any time "whether or not the executive officer has requested applications."

We're concerned that the proposed new legislation gives such far-reaching powers to the unelected EO when it comes to licensing, the details of which are vague. When it comes to quality and safety standards, the monitoring of services, the establishment of inspecting bodies and the penalties for non-compliance with an inspector's order, these are all yet to be determined through regulations.

The repeal of the Private Hospitals Act is highly problematic. The Private Hospitals Act is vitally important because it is a limiting piece of legislation. It was introduced to grandfather in private hospitals that existed prior to October 1973. Its primary function is to stop the proliferation of private hospitals. By repealing it, this schedule removes the existing ban on the expansion of private hospitals. I cannot be any clearer than to state that there is no reason to repeal the Private Hospitals Act unless this government intends to introduce new private hospitals.

We see this as a grave threat to our public hospital and public health care system and we will take strong action to oppose it. We've been down the road of privatization before. Has this government learned nothing?

The new legislation is basically a redesign of the Independent Health Facilities Act, but that act has been problematic since its introduction in 1989. The regulation of private clinics has been poor, and repeated issues of poor or even dangerous quality of care have arisen. This privatized model of hospital care is a proven failure. It should not be expanded.

Despite some progress in 2013 to halt the contracting-out of public hospital services to private clinics, sadly we now see that Bill 160 is just the latest kick at the privatization can, an attempt to rebrand IHFs and private hospitals as community health facilities, and to refocus the government's efforts on expanding these private facilities. This is absolutely shameful.

I'm going to skip to the end because I don't have a lot of time.

Why not focus on providing care in public hospitals? It is not a secret that Ontario's public hospitals are now experiencing unparalleled rates of overcrowding as a result of years of deep cuts to public hospital beds, services and staff. Hospitals all across the province are reporting dangerous occupancy rates of more than 100%. But instead of focusing on fixing the problems our system faces by investing much-needed funds into our public hospitals, the government has again chosen the privatization route—to download services to lesser-regulated facilities who cut costs by cutting corners, where the workforce is paid less and treated more poorly, and where patients are increasingly forced to pay for services out of pocket.

The Chair (Mr. Grant Crack): Thank you very much. We'll start with the third party. Ms. Gélinas.

M^me^ France Gélinas: Good morning, and thank you for coming. Could you share with us some of the issues that exist with the Independent Health Facilities Act as it is right now when it comes to oversight?

Ms. Sara Labelle: They don't have any.

M^me^ France Gélinas: Thank you. So here we are. In Ontario, the privatization of our hospital programs and services has been phenomenal. It has increased exponentially to the point where we have over 1,000 private, for-profit clinics in Ontario—98% of them are for-profit and 2% are not-for-profit. Now, what this act will do is open the door even more widely, that if you are not 24/7 hospital care, you are up for privatizing. And to add insult to injury, we are going to call them "community health facilities."

Can you think of one good reason why we would call a private, for-profit clinic that has nothing to do with the community a "community health facility"?

Ms. Sara Labelle: I guess you're asking me to understand what the Liberal government has been doing and, in over nine years, I, quite frankly, don't understand what they've been doing in health care. I've been watching them privatize services. They call things "community health care." They tell people that services are going out into the community, which is not happening.

I have no idea why you would want to stop calling public hospitals "hospitals" and why you would want to rename them "community health facilities," other than maybe that's a way for you to say that you're investing in health care, because now you're investing in the private sector but not investing in actual services in the public sector—other than maybe they want to not follow the Canada Health Act, which specifically speaks to the services being provided under a doctor's orders or in hospital. I can't possibly imagine why they would want to rebrand, but it's very concerning, considering that they haven't done the right thing in health care since they've been in power.

M^me^ France Gélinas: What will happen if we name all of those private, for-profit clinics "community health facilities"? What do you figure people will think when they hear about a community health facility?

Ms. Sara Labelle: Well, people will think, mistakenly, they're getting services in their community because the community health facilities—what we have seen in

independent health facilities and private clinics over the years is that they skim the cream. They pick and choose the services they want to offer, they introduce user fees, they charge people for some of their services, and they do nothing at all to improve the quality of care. In fact, they help increase the wait times in hospitals.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Grant Crack): We'll move to the government side. Mr. Anderson.

Mr. Granville Anderson: Thank you for your presentation. I take an opposing view to that. First of all, we haven't cut health care spending. If you look, it has increased exponentially year after year after year. There are no cuts to health care spending, so I take issue with that. But that's not what we're here to debate. We're here to try to do what we can to improve our health care system.

Relooking at something or reopening an act doesn't mean you're opening it to privatization. We are not a government that believes in privatization. We're probably strengthening the act against privatization. So I take the opposing view to that.

I'm not sure why you think this would lead to privatization. Maybe you know something that, as a government, we do not know, but we're not going down the privatization route. We're trying to tighten that up. That's what we're trying to do by doing that. So I'm not sure where you got the notion that we're trying to privatize more of our health care system. No. That's contrary to our fundamental and core beliefs.

Ms. Sara Labelle: Okay, so I guess there wasn't a question there, but you and I disagree, and we have on many occasions, on health care and the Liberal government's track record. I do think this is the government's intent because that's what it says. When you repeal the Private Hospitals Act, which was legislation to restrict private hospitals in the province of Ontario, what other conclusion could people take from that?

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It is not about strengthening health care; it is about more privatization. This is not the first road of privatization that this government has gone down. I work in the public sector, and I have worked in the public sector since 2004. Services are being privatized from our hospitals at a phenomenal rate. You and I disagree on that, and we always will disagree. That is why we came to that conclusion, because when you repeal the Private Hospitals Act language that restricted private hospitals, there is no other conclusion to be made from that.

Mr. Granville Anderson: Well, we differ on that. Another aspect: We speak of overcrowding in hospitals. Are you supportive of our allowing paramedics more leeway to determine where patients should go and to make the determination whether a patient is capable of returning home or going to a hospital? If a patient needs to go and be in a hospital, that's where they should be. But do you agree that there are patients who end up in an emergency room who don't really need to be there? Do we agree on that?

Ms. Sara Labelle: I think you're asking me to comment on the piece of legislation under the Ambulance Act, and you're asking me to comment on whether I think it's appropriate for paramedics, who are not physicians, to make a decision without any diagnostic testing on whether a patient should be released or whether they should go to a hospital. I will not take a position on that. I am not a physician, and I don't think, clinically, I have the ability to make that decision.

Mr. Granville Anderson: Thank you.

The Chair (Mr. Grant Crack): Thank you very much. We'll move to the official opposition. Mr. Smith.

Mr. Todd Smith: Ms. Labelle, you prepared for 10 minutes?

Ms. Sara Labelle: Yes.

Mr. Todd Smith: You got through that very, very well and quite quickly.

Ms. Sara Labelle: Oh, I didn't get through it all.

Mr. Todd Smith: However, I will give you three minutes. You intended to have five, but I'll give you three to try to get through some of your other concerns on Bill 160, because I know you have many. Take your time.

Ms. Sara Labelle: Okay. I did give a copy of the presentation.

I think the main thing is under quality standards. That is the main concern under this, that they're not protected by law for so-called community health facilities.

Schedule 9 predicates that quality and safety standards, like so many other important aspects of this legislation, are to be outlined in future regulations; however, licensees or, rather, private clinic owners, can actually be their own quality advisers with the written approval of the EO. This is problematic, especially where quality standards are already so different between public hospitals and private facilities. In fact, the act does nothing to improve safety regimes when it comes to private clinics, which have been plagued with serious quality and safety concerns.

Just look at the example of the private endoscopy clinic in Ottawa which, in 2011, had to notify 6,800 patients that they were at risk of having contracted HIV and hepatitis B and C as a result of improper sterilization of equipment.

A major part of the problem is that different kinds of private clinics face vastly different types of inspections. The types of clinics exposed for shortfalls related to inspection and quality by the Auditor General in 2012 are the same facilities that the government would now like to expand and rebrand as community health facilities.

Public hospitals, on the other hand, are required by law to have a host of quality protections. Over decades, the quality regime in public hospitals has expanded to include robust daily oversight. In comparison, the enforcement regime envisioned in this new act is reactive and almost all meaningful details are left to regulations.

That was getting into the end of my presentation, but the real concern is no oversight. The regulations are not the same. Inspections are not occurring under the private facilities. So if you expand the private facilities and

expand private hospitals, then they will not be covered under the same legislation and regulations that cover public hospitals, and quality of care will go down.

Mr. Todd Smith: Thanks for your presentation.

The Chair (Mr. Grant Crack): Thanks to both of you for coming before committee this morning. We appreciate it.

COUNTY OF OXFORD

The Chair (Mr. Grant Crack): Next on the agenda, from the county of Oxford, we have the warden, Mr. David Mayberry. We welcome you, sir. You have up to five minutes for your presentation, and I believe you have other guests with you as well. Feel free to introduce everyone, and again we welcome you to committee. The floor is yours.

Mr. David Mayberry: Well, I find it difficult, even as a local politician, to speak in less than five minutes, but I'll do my best. I guess I should properly introduce myself. I'm David Mayberry. I'm warden of Oxford county and the chair of the Oxford County Board of Health. With me this morning, I have Lynn Beath, the director and CEO of Oxford county health unit; Dave Marr, who is a member of the board of the Elgin and St. Thomas health unit; and Cynthia St. John, who is the executive director of the Elgin and St. Thomas health unit.

I'm here today in regard to Bill 160, the Strengthening Quality and Accountability for Patients Act, 2017, and, more specifically, the Health Protection and Promotion Act. Earlier, in September, the counties of Oxford and Elgin—or the Elgin-St. Thomas health board—began exploring the opportunity for the two health units to merge into a single unit to serve our small urban and rural communities. As a regional municipality, the county of Oxford is the governance body for the delivery of public health unit programs and services. As a result, the county of Oxford is specifically named within the HPPA with regard to the non-applicability of certain sections and subsections within that act.

Through conversations we've had with the Population and Public Health Division of the Ministry of Health and Long-Term Care regarding the merger of these health units, it was identified that amendments to the HPPA are required for the Oxford county health unit to merge into a single health unit with Elgin.

Last Friday, we announced to the public our intention to merge—not only our intention but in fact our desire—and to create a single unit to serve our communities. The intent was formalized through the signing of letters of intent last week, both at Oxford county council and at the Elgin-St. Thomas board of health meetings.

Our next step is to actually approach you and ask for a legislative change to remove special distinctions for the county of Oxford within the Health Protection and Promotion Act so that the merger can proceed. Within Bill 160, currently before the standing committee, we have what is essentially our only opportunity to seek the necessary legislative changes required for us to proceed with this merger. I am asking you to consider striking the words "county of Oxford" in the four sections—sections 1, 49, 55 and 96. Removing the county of Oxford from these sections of the HPPA will enable Oxford and Elgin-St. Thomas to seek the necessary changes to the regulations which are required to form the new health unit entity through merger.

Our health units have a history of collaboration and share similar geographic, demographic, health status and population characteristics. A merged Oxford and Elgin-St. Thomas health unit will align with the findings and observations of a number of reports done over the past 20 years. Our goal, we hope, will achieve some of the desired goals such as:

—a reduction in the health units;

—creating an autonomous health board for Oxford, which it hasn't had;

—more consistency in skills, experience and priorities of the board of health; and

—better integration of public health within the health system.

Oxford and Elgin share a viewpoint that a local solution, one that offers equitable representation from all across our municipalities, will strengthen public health programs and services for our small urban and rural communities. Through this merger, residents will continue to have a significant voice through their elected and citizen appointments and will continue to receive public health services through the people they know and, more importantly, the people that know them.

Elgin and St. Thomas health units have a long history, a rich history, of working together, sharing similar characteristics across the people we serve, as well as sharing the same LHIN and school boards. Each of our communities has unique needs, separate from each other, and those will continue to be met. We're confident the model we are putting forward will ensure strong, vibrant and efficient public health programs and service now and for the future.

I want to conclude by simply saying I can't overstate how important removing this one portion, or one section, the words "county of Oxford," from these sections is for us to be able to proceed to the next step, and the next step after legislation is regulation. We would like to accomplish this probably by the spring of 2018, and so we are before this standing committee asking for your respectful consideration of our request. It only impacts Oxford county—no one else is being impacted by our request—and it's simply deleting four words in four sections. I'd be happy, sir, to answer any questions.

The Chair (Mr. Grant Crack): Thank you very much, Mr. Warden. We'll start with the official opposition: Mr. Hardeman.

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Mr. Ernie Hardeman: Thank you very much for your presentation. I did speak to the minister yesterday and mentioned that you would be coming today and, hopefully, that he would support these amendments when they were put forward. He said that he was going to

review it, and he, at that point, said he could see no reason why they wouldn't do it.

I guess, for the committee's purposes, I just want to point out, Mr. Chair, the reason the words "the county of Oxford" are there. Everyone will remember, back in 1973 or 1974, all the regions were formed under a regional act, and they got certain authorities and so forth. Oxford did it in 1975 under their own volition. It is a region, for all practical purposes, but it retained the stature of a county and it did not change its outer boundaries. So in every piece of legislation that deals with regional and county government, Oxford is always mentioned separately.

It's never been a problem until now, because for this amalgamation to take place we need Oxford to be designated as a county—not as a region; as a county. The county of Elgin is here, and they can already do this amalgamation, but the county of Oxford is stuck because it's being deemed a region by this inference in the act. That's the only thing that they're asking for. I guess I'll just ask, Mr. Warden: Is that a reasonable explanation of what we're asking for here?

Mr. David Mayberry: Certainly, the ability for Oxford to move beyond the Oxford borders for public health or a number of other things is restricted. So having the county of Oxford listed in each of these sections actually prevents us from being able to go to any of our neighbours. It wouldn't matter who it was. In this case, we'd like to deal with Elgin, but it simply prevents us from doing it. It stops dead any further discussion or whatever until we can get this changed. Being that the act is in front of Parliament right now, it would seem that it would be the appropriate time—in fact, probably our only time—to get this small change done so that we can proceed in a manner we'd like to.

Mr. Ernie Hardeman: I think that fairly much covers it. Again, I hope the committee will support these amendments when it comes forward at clause-by-clause. I see in your presentation, you point out what needs to be done. Hopefully, before we get to clause-by-clause for Bill 160, we can bring forward the amendments that will accomplish this. Thank you very much for your presentation

Mr. David Mayberry: We appreciate that. Thank you.

The Chair (Mr. Grant Crack): Thank you very much. Madame Gélinas, from the third party.

M^me^ France Gélinas: First of all, thank you for what you do for your county and for being members of the board of health. I appreciate that very much.

I will play the devil's advocate: Can you think of anyone in your municipality, in the geographical area that you serve, that would be opposed to the two health units merging?

Mr. David Mayberry: I think that was probably where we started: What would be the worst possible case? Quite frankly, the discussion around the Oxford board of health or county council was that very discussion: "What is the downside of doing something like this?" We see lots of upside, but, in the discussion with the warden of Elgin, he and I shared exactly the same things: Are we going to be able to have local attention to local problems?

In Oxford, we have several, let me call them, ethnic groups. We have a number of Old Order Amish that have specific health requirements, as do some Old Reformed folks. Elgin has the same situation through Mexican Mennonites and—I'm trying to remember the other group. Public health has historically had to have slightly different programs—or slightly different approaches, I suppose, is the right word—to be able to engage that community. That's one of the reasons why we actually make a good pair, because we understand those particular needs for helping certain segments of the community.

M^me^ France Gélinas: Do both of your health units have a medical officer of health right now?

Mr. David Mayberry: We have an acting medical officer of health. He will be retiring next spring, which is another reason why we think this is an opportune time for us to sort of seek this opportunity to merge. We've had discussions at the county council level about, is 100,000 people really enough for a public health unit? As long as I've been on county council it comes up once in a while, but it seems like this would be an ideal time. The medical officer of health in Elgin actually takes care of us when our medical officer of health is on holidays or whatever, so that relationship has been working well, and we appreciate it.

M^me^ France Gélinas: Was there any talk as to whether both offices would be maintained or any of this, or is it too early?

Mr. David Mayberry: That's part of the negotiation. Certainly, our intent would be that we would probably keep the office that we have currently in Woodstock. Elgin has a relatively new building. The office in Woodstock is in the old jail. Historically and politically, it is probably essential that we continue to use that building, but I think we see—they work together now. We have people who work out of our office on a regular basis. Whether they're working out of the St. Thomas office or Woodstock office, I'm not sure it would really matter.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Grant Crack): We'll move to the government: Ms. Wong.

Ms. Soo Wong: Thank you so much for being here. I apologize for being late; I got dragged to another meeting.

I come from public health, so I know exactly what you guys are doing. I want to say thank you for what you do, because primary health care comes from public health and population-based health.

I notice in your written submission, you talk about how Elgin and St. Thomas and Oxford counties are from the same LHIN, so I'm going to assume the LHIN supports this presentation and supports this merger, or amalgamation. Am I correct to say that?

Mr. David Mayberry: We had discussed it. Go ahead, please, Cynthia.

The Chair (Mr. Grant Crack): Just state your name for the record.

Ms. Cynthia St. John: My name is Cynthia St. John. I'm the executive director at Elgin St. Thomas Public Health.

I just want to acknowledge that I'm actually on the South West LHIN board, so the LHIN has been notified, and I know of no reason why they would object to it whatsoever.

Ms. Soo Wong: That's good.

I know Ms. Gélinas asked the question about the MOH—medical officer of health—so I'm happy to hear that we're not going to lose a job, because I hear that there's an impending retirement.

My other comment to you: How does this proposed amalgamation, merger—call it whatever you want—improve services and care? That's what the bottom line is, right? If it isn't, why are we here? I want to hear, how do you ensure those services will be improved or even enhanced? Let's call it the way it is.

Mr. David Mayberry: I appreciate that. I think that was one of the questions that was asked of our board of health: "Does this make things better?" The reality is that at 100,000 people, you don't get enough of any one thing to maybe deliver or to create the expertise within the community; at 200,000 people, maybe you do. I'll let Lynn or Cynthia speak to this, but I think part of it is to get to a scale that we're now big enough that we can attract the people we need or that we have enough need to attract people.

Lynn, did you want to—

Ms. Lynn Beath: I'm Lynn Beath. I'm the director for Oxford County Public Health.

Just to build on what Warden Mayberry had said, one of the things with the new modernized standards that are coming forward in the new standards coming out for public health and the capacity for some of those things, individually, we would barely be able to handle some of the new requirements, and they're all very good requirements, moving us in the right direction for public health. What's very interesting, with our two health units, is that we each have capacity in different areas that we have already realized that we can leverage and have some strength and be able to pull together and not have some duplication, but actually enhance and be able to do some things that alone we would not be able to do because of our smaller sizes.

Ms. Soo Wong: My last question is, is it a unionized environment, and what would the union situation be in this merger?

Mr. David Newberry: I believe that the county has two unions, and I think Elgin St. Thomas has three. That is part of the discussion, about how do you bring those together? In Elgin, as well, we have excellent staff. We don't want to upset them; we actually want them to all show up for work and do the absolutely essential work that they do every day. Historically, Oxford has had exceptionally good luck in dealing with unions and dealing with their staff and treating them with respect, and I suspect that this merger will just be one more step, that eventually the unions will figure out how they have to solve the problem. We'll continue to work with whomever.

Ms. Lynn Beath: We've already had discussions with all of our unions—some initial discussions.

Ms. Cynthia St. John: If I could?

The Chair (Mr. Grant Crack): Very quickly.

Ms. Cynthia St. John: Okay. So just very quickly, also in answer to your question, I would say that both boards are very committed, for any efficiencies to be found—and there will be some—in our intent to reinvest those in front-line program and service delivery for our communities. Thank you.

Ms. Soo Wong: Okay, that's great. Thank you.

The Chair (Mr. Grant Crack): Thank you very much, Mr. Warden and guests with us this morning. We thank you for coming before committee and sharing your thoughts.

I'll just remind all members of the committee that we will meet tomorrow morning at 8:30 to continue the public hearings. At this particular point, there being no further business, this meeting is adjourned until tomorrow.

The committee adjourned at 1010.

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